A Study of Indian Families Adopting Indian Children

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Overview

India is a multicultural, multilingual and multi-religious country. Any issue is complicated to unravel and understand, both for foreigners and for many native-born. Adoption is no different—it is difficult to decipher all the complexities that affect adoption policy and practice in India. According to Ursekar (1976) adoption is subject to different rules and laws according to religious sect. Since India is a land of many religions including Hindu, Muslim, Zorastiran, Christian, etc., adoption is multifaceted.

While posing a challenge, it is critical to have current and research based information on the issues in Indian adoptions. Children form about one third of the population of India. It is estimated that there are over 304 million children in India. Of these, about 4% are estimated to be orphaned (over 1,200,000 children) and over 100,000 are in institutions (Bharat, 2002). According to Raju (1999), the number of destitute children, especially in major cities, is growing. Due to poverty, many children enter the child welfare system. In addition to poverty as a risk factor, a large percent of children are abandoned or voluntarily relinquished because of being born to a single mother. There are strong social mores and values against unwed mothers that results in increased risk for abandonment (Baig & Gopinath, 1976).

Similar to the countries of Eastern Europe, former provinces of Soviet Russia, most of Asia, and most of central and South America, India relies heavily on institutions and orphanages, known a child care centers. The private or nongovernmental sector provides most of the institutional care. Phadke (1993) indicates that in the early 1990s there were about 1000 institutions in the nongovernmental sector and 500 in the governmental sector caring for children. Bagley (1993) indicates that the orphanages provide only minimal care and is not an adequate substitute for family life. Phadke (1993) claims that institutions are inadequate in capacity and unsatisfactory in quality. To add context to this point, Bagley writes:

> "…The standard of care is adequate from the point of view of health and nutrition and is certainly better than the lot of many children in the slums; but the poor ratio of staff to children, and the strict regimes observed are quite different from those familiar in Western settings" (p. 80).

Similar to unconfirmed reports about children in institutional care in Eastern Europe before the fall of communism (Groza, Ileana & Irwin, 1999), Bagley (1993) suggests that half of infants placed in institution die within a few months. He indicates that the reason is not poor care but because of the health status of the child before abandonment. Baig and Gopinath (1976) indicate that mortality rates in some institutions as the the mid 1970s was 75 percent with girls most at risk for death. While Padke (1993) concurs that the health status before placement is a factor, he also asserts that institutions do not adequately remedy pre-existing health problems. Chowdhry (1980) writes institutionalization not only fail to solve problems but creates more problems than it solves. He indicates that India can save on future expenditures on interventions for the social problems of adults by creating alternatives to institutionalization. It is from this perspective that

he promotes funding for foster care and adoption as well as family support programs to strengthen and preserve poor and at-risk families.

Adoption is not a panacea to the multiple problems that result in children entering the child welfare system. However, it is a vital component in a system of care that promotes permanency and well-being for children. Creating or expanding a family through adoption is positive for children and families. Adoption is seen as the best means to restore family life to a child deprived of his or her biological family (Gokhale, 1967). Raju (1999) found that two-thirds of India people view adoption positively. In India, adoption is as old as Hindu law (Chowdry, 1980) and is mentioned in Indian mythology (Stiles, Dhamaraksa, de la Rosa, Goldner, & Kalyanvala, 2001) and in histories of kings such as that of King Dashratha (Baig & Gopinath, 1976). In Indian mythology, for example, Sita from the Ramayana epic was adopted by a king, and Sakuntala was adopted and raised by a spiritual guru. Adoption practice in ancient times was important for old age protection, perpetuation of the family name, security of family property and solemnization of the last rites of the father (Baig & Gopinath, 1976). Much of the history of adoption has been lost (Bagely, 1993). However, under Brahmnical influence, a special religious significance was attached to having a son (Baig & Gopinath, 1976; Bagely, 1993). Traditionally, Hindus adopted male children when they had no heir. Even if a family had daughters, inheritance was passed only through the son and the son was expected to care for parents in their old age. While adoption was practiced, the adopted son was usually a relative (Baig & Gopinath, 1976) and a similar caste (Bagely, 1993). The adopted son from the date of adoption is regarded as if he were born into the family. Historically, children abandoned were not adoptable because nothing was known of their family and background. The lower castes, or untouchables, traditionally were not allowed to adopt.

While adoption laws later extended to girls, up until the early part of the 1980s girls did not have the same status and their adoptions was more rare than the adoption of boys (Chowdry, 1980). This bias towards males may account, in part, for Bagely's (1993) report that two-thirds of the children in institutional care are females. However, in the last 10 years, Dixit (2001) reports a change in adoption choices. Ten years ago, there was a wait for male children but females could be immediately placed. Now, both male and female child placements take 8-10 months and families are increasing interested in adopting females as well as males. In addition, while the

families that adopted were childless couples, more families are coming forward to adopt out of choice.

Raju (1999) found class difference in views towards adoption. In particular, upper income families express a preference for female children while lower income families prefer males. The more complicating issue in India adoptions is religion. Children are born into a religion and inherit the religion of the parents. If the father is unknown, the child inherits the religion of his or her mother. The Islamic stand on adoption is that it is forbidden by the *Koran*. The Hindu Law on Adoption (1956) provides a uniform legal framework for adoption for Hindu families (Ursekar, 1976). Hindu Adoption is irrevocable. Hindu birth parents can relinquish their children but once the child is adopted under the Hindu Adoption and Maintenance Act, it cannot be changed or reconsidered. For those families of other religions (for example, Muslim, Zoroastrian, or Christian), there is a legal framework for guardianship. The biggest difference between these 2 legal statuses is around inheritance. Under the Hindu Adoption and Maintenace Act of 1956, children who are adopted are recognized as if they were born into the family and are subject to the rights of inheritance. Children in guardianship arrangements have no such rights, although families can create trust funds, investments and wills for these children. While legally different, for most parents and in the practice of the agencies, both are treated essentially as adoptions.

Adoptions of nonrelatives is relatively new in India and has increased over the last two decades. According to oral history gathered as part of this project, the first child care center was created in the local hospital after concerned citizens became aware that the mortality rate for abandoned infants approached 100%. With a room donated by a local hospital and the efforts of community volunteers, 6 abandoned children were placed in a child care center. Five of the children survived and were placed in adoptive families. Initially, the children were placed when a child had died in childbirth. A physician would request that one of the abandoned children of the same gender go to the woman who had lost a child during delivery. After a few years of this arrangement, adoption practice was expanded. Again, at the request of a physician working with a couple with infertility problems, he or she would request a placement to save the marriage. In these arrangements, the adoptions were often secret and there was no formal, legal process in the adoption.

Over the last 20 years, adoption involved into the process that it is today—with families applying to adopt, having a home study completed, working with an agency for placement, and going through the court system. Although there has been scandals around adoption in 2001, most adoptions are handled legally and appropriately through the established systems.

Adoption is a viable option for creating or expanding a family. It is the best option for children who cannot reside with their birth families. Several studies have been conducted on India adoptions in the last 30 years. In a 1984 study of Indian adoptions, Billimoria (1984) found that the majority of parents were satisfied with their children and most children were reported free of physical, intellectual and emotional difficulties. Bharat (1993) found that the major reason couple adopted was infertility. Vaidya (1998) noted that families adopted even when they were able to conceive biologically, suggesting that some families were choosing adoption for other reasons than infertility. Raju (1999) cited an undocumented study that found some families were

willing to adopt children with special health needs, indicating some community capacity for expanding the definition of who is an adoptable child. As Phadke (1993) suggests, more information is needed to build support and capacity for Indian adoptions. It is within this context that this study was undertaken.

METHODOLOGY

The purpose of this project was to provide research-based information about the experiences of Indian families who adopted Indian children as part of program evaluation of BSSK. The project was designed primarily as a program evaluation. There are two major types of program evaluation. The first type focuses on program processes (process or system evaluation). The second type focuses on program outcomes (outcome evaluation). Process evaluation in this project examined activities and services as it related to the adoption and post adoption period. Outcome evaluation assesses the immediate and long-term results as a consequence of program activities. We used both qualitative and quantitative approaches to address evaluation. Qualitative approaches tend to produce rich and descriptive findings. Quantitative approaches reduce activities and outcomes to numeric form, which allows mathematical manipulation of the data. A mix of both approaches produces the strongest information for documenting program development and effectiveness. The evaluation was organized around the following questions:

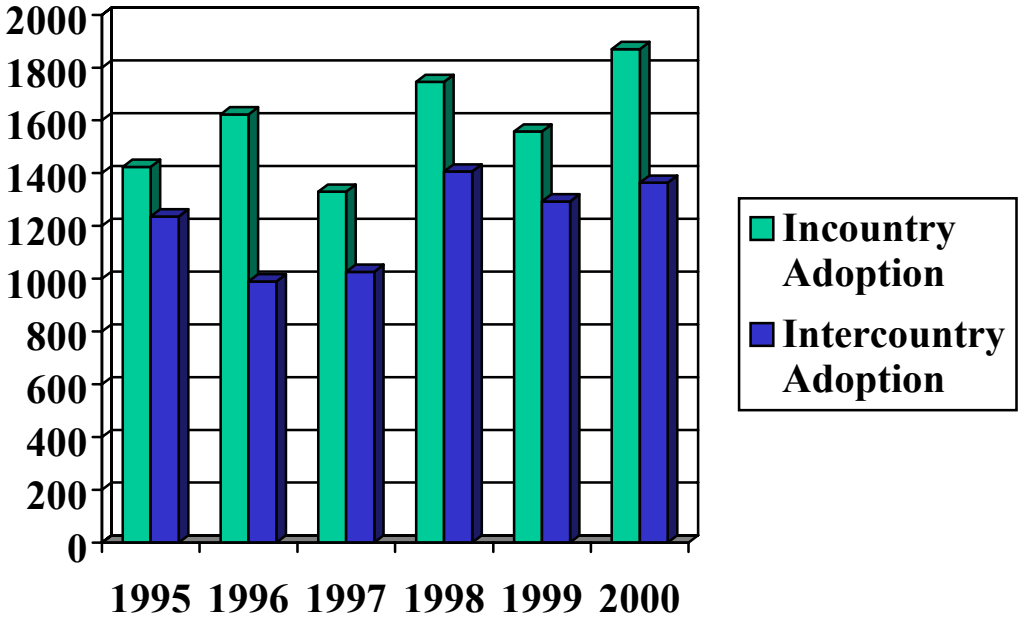
- What problems/issues are families facing related to the adoption/child?
- What post adoption resources have they found/would like to find?
- How could BSSK's adoption program be improved?
- What are the indicators of success in adoptive placements?

Data for the project were collected in collaboration with Holt International Children's Services (abbreviated as Holt). Holt is a private, nonprofit agency recognized as the unparalleled leader in the field of international adoption and permanency planning for children. Holt has been working in India for over 20 years. The primary partner agency in India is Bharatiya Samaj Seva Kendra (BSSK), located in Pune, India (near Mumbai).

Holt pioneered the concept of inter-country adoption in the 1950's in response to the needs of orphaned children in Korea. In the four decades since, more than 100,000 children have found permanent homes through adoption and other child welfare programs of Holt. Holt has programs in China, Ecuador, Guatemala, Hong Kong, India, Korea, Philippines, Romania, Thailand, Vietnam and the United States. Holt works to secure permanent solutions for children with these priorities:

- Return the child to the biological family if possible and appropriate for the child.
- Place the child in an adoptive family within the birth country.
- Place the child with an adoptive family internationally.

In India, there has been a steady increase in the number of adoptions. According to the data provided by Central Adoption Resource Agency (CARA)[2], the steady increase in adoptions is due largely to the increase in domestic or incountry adoptions. For example, of the 2660 adoptions in 1995, 1424 were from domestic, incounty adoptions (54%). In 2000, of the 3234 adoptions, 1870 were domestic, incountry adoptions (58%). The following figure summarizes the adoption data for India from 1995 to 2000.

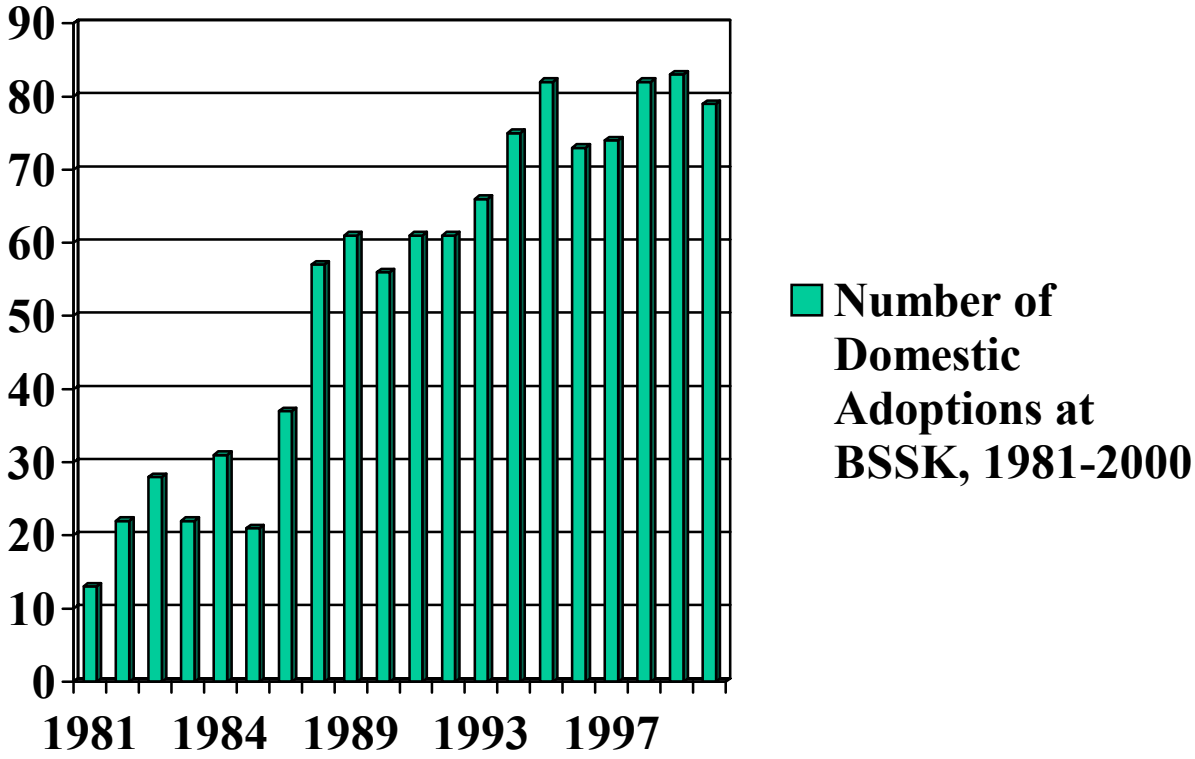


INDIAN ADOPTIONS 1995-2000
Source: CARA

In the last 20 years, BSSK has placed with over a thousand Indian adoptive parents in India and overseas. The following diagram shows adoptive placements over the 20 year period. BSSK facilitated the domestic adoption of 13 children in 1981; by 2000 this had increased to 79 children. From these records, 1084 children had been placed.

[2] CARA is an autonomous agency under the Ministry of Social Justice and Empowerment, Government of India. It was established in 1990 to deal with all matters concerning adoption in India. For additional information, see their website at http://www.adoptionindia.nic.in

The number of adoptions by year is included in the following table:



Year	Number of Adoptions
1981	13
1982	22
1983	28
1984	22
1985	31
1986	21
1987	37
1988	57
1989	61
1990	56
1991	61
1992	62
1993	66
1994	75
1995	82

1996	73
1997	74
1998	82
1999	82
2000	79

The in-country breakdown used in this project was:

374 families in Pune City
672 families in other parts of India
1046 Total in-country adoptions

From the records, there were 1084 placements but only 1046 families listed. This is a difference of 38 cases. In 30 cases, it was the same family that had adopted two children. The remaining 8 cases were disruptions or child deaths. BSSK had placed 1325 children over their 20 year history; 241 families were Indian families from abroad that adopted, leaving 1084 in-country placements. For this project, we used the 1084 placements for which there were records, recognizing that there may have been more placements early in the agency's history but families in the past did not give the agency their address when they moved and contact with them has been lost.

Sample. A power analysis was conducted prior to data collection. Two approaches were used in the power analysis. One power analysis focused on a multiple regression model using 10 independent variables.[3] Three of these predictors would be dichotomous variables to represent key contrasts (e.g., India vs. U. S. families, mailed versus face-to-face interviews). Assuming these variables explain 25% of variation in the outcome variable, a sample of 60 cases will have a power of 0.81 and a probability of making type I error (alpha) of 0.05. To interpret this recommendation, if we collected information for 60 cases per group (60 Indian families so that we collect date on 30 Indian families in Pune, 30 Indian families outside Pune) and have no missing information, provided that adoption research findings from the United States are applicable to adoptions from India, we have a statistically appropriate sample. Assuming a response rate of 60% of families who agree to participate in the study compared to those contacted for mailed surveys, we would need to generate a random sample of 100 families per group to yield 60 participants. Assuming a response rate of 37% of families who agree to participate in the study compared to those contacted for face-to-face interviews (based on our experiences in Romania), we would need to generate a random sample of 162 families to yield 60 participants.

The approach assumes a medium effect. Assuming a small effect (f=.12), additional analyses were conducted. The assumptions were the same except for changing the effect sizes (from explaining 25% of the variance to 12% in the regression model). For the regression analysis, the sample size required increased from 60 to 130. Assuming a response rate of 60% of families who

[3] The model assumed 10 independent variables (the 7 from my prior work that is referenced at the end of this note plus 3 dummy variables to represent contrasts between India vs. US, mail survey vs. face-to-face interview, and in the US subsample the Indian parents vs. non-Indian parents); see Rosenthal, J., & Groze, V. (1992). Special Needs Adoption: A Study of Intact Families. New York: Praeger.

agree to participate in the study compared to those contacted for mailed surveys, we would need to generate a random sample of 217 families to yield 130 participants. Assuming a response rate of 37% of families who agree to participate in the study compared to those contacted for face-to-face interviews (based on our experiences in Romania), we would need to generate a random sample of 350 families to yield 130 participants.

The estimates assist us in looking at the sample in contrast to our conceptual framework and the resources available to the project.

Methodology: Both a mailed survey and face-to-face interviews were used to collect data. A random sample of families were selected to take part in the study. A random sample of amilies living in Pune were sent a questionnaire and asked to participate in interviews (374). A random sample of other families living outside Pune (672) were asked to participate in a mailed survey only. To obtain a random sample, from a maser list of families, every other family was chosen to be solicited to participate in the study. Once selected, every family received a unique ID number. While English is the common language, a significant percent of families from Pune and the surrounding area are more comfortable with Marathi. Therefore, letters and questionnaires were translated into Marathi.

The agency recognized early in the sampling process that there were some difficulties in their Management Information System and that complete mailing information on families was missing. When the random sample of Pune families was drawn from the 374 placements, 187 families were in the sample. However, no address could be located for 49 families (26% of families) due to change of residence made by families and families not keeping BSSK informed of their address change. One hundred and thirty eight (138) families from Pune received a survey in the mail and were invited to participate in an interview in their home or office; the location of the interview was chosen by the family. The interview format was structured, but in a face-to-face interview we could probe the issues and experiences of families. When the random sample of 336 out of 672 families living outside of Pune was drawn, 63 had no address (19% of families). Two hundred seventy three (273) families were the sample drawn from families living outside of Pune. Mailing addresses were missing or families were not included in the sample for the following reasons: (a) families had not informed the agency of their new address; (b) the adoption was a secret and the family had requested the agency never to contact them; (c) some families moved out of the country for work; and, (d) death or disruption of the adoptee.

The only data about the family recorded by BSSK was the family name, address and ID number. Starting 2 weeks after the letters were mailed, BSSK staff contacted families to set up a date and time for interviews. Refusals to participate were recorded. BSSK knew whether a family agreed to be interviewed but did not know the family-specific information from an interview. Only the interviewers knew family specific information and all results are aggregated for reporting purposes.

The Indian staff conducting interviews were volunteers for or staff at BSSK. They had no ongoing contact with the adoptive families and provided no services to these families. The interviewers were professional people with an interest and commitment to child welfare. A one day of training/team building about basic interviewing skills and the project protocol, including

confidentiality and the safeguards for human subjects, was conducted prior to interviews. The interviewers were reminded that they are prohibited from discussing identifiable results obtained from family interviews. Most of the volunteer had minimal experience in conducting research interviews.

Mailed surveys were returned in an enclosed, stamped envelope. Surveys were mailed 6 weeks before interviews were to begin. A reminder notice was sent to families to prompt them to return the questionnaire.

Adoptive families from Pune were interviewed after written consent was obtained. Each interview was expected to last approximately 60-90 minutes. Half way through the interview the interviewer reminded the participant that they could terminate the interview at any time without consequence. Interviewers made summary notes about from the interviews and added any additional impressions they had about the interview once after the interview was complete. Once a week, the interview team processed each interview to highlight what they had learned and what they felt the implication for policy and/or practice were as a result of the interview. Because of a mailing mistake, many families received a copy of the questions that were structured for the interviews before the interviews took place. Some made written comments and these were given to the interviewer at the time of the interview or included with the questionnaire that was mailed back to the agency.

No individual family response was tracked back to a specific family.

Measures. In previous research, we used a similar questionnaire as the one developed for this project for adoptive families in the United States and Romania (see Rosenthal & Groze, 1992; Groze, 1996; Groza and the Bucharest Research Team, 1999). Standardized measures included the Child Behavior Checklist (CBC), the Behavioral and Emotional Rating scale (BERS) and the Parenting Scale.

The CBC has a reliability of .9 (Achenbach, 1991; Achenbach & Edelbrock, 1983). The CBC provides measures that contain 5 subscales assessing internalizing problems plus a summative Internalizing Scale, and 3 subscales assessing externalizing problems plus a summative Externalizing Scale. Over a one-year period, the mean r was .75; over a two-year period, the mean r was .71. Subscale alphas range from .54 to .96. The 5 subscales assessing internalizing problems are withdrawal, somatic complaints, anxiety/depression, social problems, and thought problems. The 4 subscales assessing externalizing problems are attention problems, delinquency, and aggressiveness.

The Behavioral and Emotional Rating Scale (BERS) is a standardized, norm-referenced scale designed to assess the behavioral and emotional strengths of children ages 5 to 18. It is a 52 item checklist normed on children not identified as having emotional and behavioral disorders and on children with emotional and behavioral disorders. It assess 5 dimensions of childhood strengths: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning and Affective Strength. The BERS subscales have alphas ranging from .87 to .96; it has an overall reliability of .97 (Epstein & Sharma, 1998).

The Parenting Scale (Arnold, O'Leary, Wolff, & Acker, 1993) is a 30-item instrument developed to assess problematic discipline practices. The PS comprises 3 subscales: laxness, over-reactivity, and verbosity. The PS has good internal consistency with alphas for the total scale of .84, .83 for laxness, .82 for over-reactivity, and .63 for verbosity. It has good test stability with a test-retest correlation of .84 for the total scale, ..83 for laxness, .82 for over-reactivity, and.79 for verbosity. It has also good concurrent and discriminant validity. The PS distinguishes between mothers attending a behavior clinic to improve their child management skills and non-clinic mothers. These two groups are designated as "Clinic Mothers" and "Nonclinic Mothers." Nonclinic Mothers are akin to the typical mother. It is significantly correlated with the CBC (see also Irvine, Biglan, Smolkowski, & Ary, 1999).

The CBC assesses behavior issues, the BERS assesses the behavioral and emotional strengths of children, the PS measures discipline practices, and measures of attachment, development, service usage and needs are included in the questionnaire. Multiple indicators of adoption outcomes are separate questions on the survey (disruption, out-of-home placement, family satisfaction/impact of adoption, thoughts of ending the placements, etc.).

For the interviews, questions were adapted from the Minnesota/Texas Adoption Research Project conducted by Grotevant and McRoy (1989). For this project, the focus was not on hypothesis testing but on understanding and describing adoptive family life and issues, searching for ways to improve adoption policy, practice and service delivery in India. A copy of the questionnaire and instruments are included in the Appendix.

RESULTS

Response Rates

Out of 138 families solicited to participate in the survey study from Pune, 94 responded to the survey, for a response rate of 68%. In addition to the survey, 138 families from Pune were solicited to participate in interviews. One hundred thirteen families agreed to be interviewed, for a response rate of 82%. Out of the 273 families solicited to participate in the study from outside Pune, 136 responded to the survey, for a response rate of 50%. Our overall response rate is 56% for the survey. The response rate of 81% is considered very good (Mangione, 1995; Salant & Dillman, 1994). However, Mangione (1995) and Salant and Dillman, (1994) raise concern about the quality of data when response rates are 60% or lower. In contrast, Babbie (1973) indicates that a response rate of 50% is adequate for analysis and reporting, a rate if 60% is good, and a rate of 70% or more is excellent. Visser and colleagues (2000) indicate that the response rate for mailed surveys is often less than 50% and techniques to increase rates are complex and costly, seeming to indicate that responses of less than 50% are not problematic. Thus, there are multiple ways to evaluate the response rate.

We consider the response rate to be quite good for several reasons. First, this is the first time this approach has ever been used so it is innovative for both the agency and the families. Answering mailed surveys and participating in interviews is not a cultural norm and likely affected response rates. Second, the mail service was not as reliable as we expected. Many families who received

a reminder post card indicated that they never received the survey, so another survey was mailed to them. The estimate of the number of families successfully contacted is probably exaggerated, which would mean that the response rate of successfully contacted families is higher. However, this is no way to determine the exact number of families that did receive a questionnaire.

When appropriate, data were analyzed by location to examine differences between adoptive families living in Pune and adoptive families living outside of Pune. Any significant differences are reported in the following results. In the transportation of the data from India to the United States, 4 surveys from Pune and 3 surveys from outside Pune were lost. The following analysis is based on 90 surveys from Pune, 113 interviews from Pune, and 270 surveys of families from outside Pune.

Description of the Adoptive Families

The questionnaires were completed mostly by the adoptive fathers (55%), with one-third (33%) completed by adoptive mothers and both parents completing the questionnaire together for the remaining surveys (12%). On average, adoptive mothers were 35.5 years old (std dev=5.5) at the time of adoption and 41.2 years old (std dev=7.5) at the time of the study. On average, adoptive fathers were 38.6 years old (std dev=5.8) at the time of adoption and 46.7 years old (std dev=7.3) at the time of the study.

Most families did not have other children in the home (80%). For the remaining 20% of families, about 10% had other adopted children and 10% had birth children. For 12% of families, prior to adoption they had another child in the home. These were typically birth children. About 8% of the families had another child after the child included in the study entered their home. These included mostly other adopted children but also some birth children.

Family income ranged from 9,550 rupees per year to 500,000 rupees per year; the salary of 500,000 rupees was very unusual with only one family reporting such income. On average, families made 306, 665 rupees per year. Median family income was 150,000 rupees per year.

About 60% of interviews were conducted at the residence of the family. Based on the interviews, the primary reason families adopted was infertility (81%). Infertility often resided with the mother (43%) as did reports of an inability to conceive (19%). Infertility in the father was identified in only 14% of the interviews and both parents were reported as infertile in 5% of the interviews. A humanitarian desire to adopt, unrelated to infertility or age, was expressed in about 10% of the families. Only one parent reported that she was adopted and another parent reported that her father had been adopted.

The following example of the reasons for adoption is an exerpt from an interview and typical of the stories around infertility:

> After the couple married, they had problems conceiving. They were taking fertility treatments for 17 years. The doctor said they were normal and might conceive some time. They decided not to continue to wait and made the choice to adopt.

Description of Children and Their History

About half of the children were female (53%). At the time of the study, children ranged in ages from under 1year of age to 21 years of age and were 7.3 years old, on average. They had been placed from infancy to age 7; average age at placement was 8 months. Over 40% had been placed as infants (under the age of 1) and 93% had been placed under the age of 2. The children had been in their respective adoptive placements from 1 to 5 years; average length of time in their adoptive homes was 6.6 years.

The majority of the children (95%) had been in an orphanage or institution before placement, for an average of 4.6 months. Length of time in an institution or orphanage for these children ranged from less than a month to 59 months with an average of 6.5 months. Over 90% of the children had spent a year or less in an institution or orphanage. About 10% of the children had spent time with their birth family before adoption. Length of time ranged from less than a month to 6 months with an average of 1.9 months. About 16% of children had been in a foster family prior to adoption. Length of time ranged from 1 month to 8 months with an average of 3.5 months.

Families were asked to evaluate the quality of the pre-adoptive placements. The following summarizes their evaluations. We rounded percents to the nearest whole number on all tables.

Type of Placement			
	Institution or Orphanage	*Birth Family*	*Foster Family*
Evaluation			
Excellent	63%	44%	31%
Good	34%	23%	40%
Fair	2%	6%	7%
Poor			2%
Don't Know	1%	22%	21%

For the most part, the institutions were well rated. Families were asked to report the child to staff ratio at the institution or orphanage. Most did not know. For those who did know, estimates ranged from 4 staff per 100 children to 150 staff per 100 children. Average staff to child ratio was 28 staff for every 100 children, or approximately 1 staff per 4 children.

The following table shows where children were living at various points in their development, excluding the point where they entered their adoptive families. Most families did not report this data, so it should be viewed with caution. Data were examined for only the first 24 months since the vast majority of children were placed for adoption by age 2.

Months				
	0-1	2-6	6-12	12- 24
Location				
Birth Family	10%	6%	16%	16%
Maternity Hospital	9%	1%	2%	
Orphanage or Institution	68%	88%	49%	54%
Foster Family	5%	5%	33%	29%

During the first month of life, most children were in the orphanage or institution. The first major shift occurs during the second through sixth month, with increased percents of children entering the orphanage or institution. By the first year and before the second year, the children were mostly in institutions, although one third were also in a foster home.

Health, Disability and Other Developmental Descriptions of Children

For the most part, health problems, disabilities and other difficulties were not reported for the children. No children had vision or hearing impairment, only 1 was reported to have physical disabilities, and 6 children (3%) was reported to be mildly retarded. Overall, these children do not have special physical or health needs.

Parents were asked to evaluate lags in developmental skills for their children at placement and at the time of the study. Following is a summary of their report.

Developmental Assessment		
	Percent with delay at placement	Percent with delay at time of study
Fine Motor Skills	1%	1%
Gross Motor Skills	1%	1%
Language Skills	1%	2%
Social Skills	1%	<1%

For the most part, there were no reports of developmental delays at placement or at the time of the study.

Parents were asked to evaluate sensory information for their children at placement and at the time of the study. Following is a summary of their reports.

Sensory Assessment		
	Percent with behavior at placement	Percent with behavior at time of study
Oversensitive to touch, Movement, sights or sounds	4%	3%
Under-reactive to stimulation or pain	1%	1%
Activity level too high for age	8%	15%
Activity level too low for age	3%	2%

For the most part, there were no reports of sensory difficulties at placement or at the time of the study. For children entering the family with some difficulties, most of these children had improved at the time of the study with the exception of activity level being too high. While evident at placement for 8% of the children, the amount had almost doubled at the time of the study. Still, only 3% of the families did not feel that the health or physical problems were more serious than described by the agency. The vast majority report no problems and accuracy in the information given them prior to adoption.

An adoptive mother wrote about her daughter, placed at age3, with behaviors indicative of sensory problems.

> Immediately after coming home *our daughter* (age 3 at placement) used to wet the bed and used to throw temper tantrums. She loved to sit on a swing for quite some time and used to sing; the tune was similar to Vedic mantras. She was seeking attention from her parents all the time and not interested in writing or writing. She was also very sensitive to touch and very reactive to stimulation and pain. Her activity level was low at the time of placement. She became active and smart within two to three months.

As is apparent from her comment, the difficulties disappeared a few months after placement. This is consistent with reports from many families who adopt older children, both incountry and through international adoption.

Attachment Relations

Families were asked to report on a series of indicator of the parent and child relations. The following table summarizes their responses. (Due to rounding, the percents do not always equal 100).

Assessment of Parent-Child Attachment Relations

How well do you and your child get along?	
Very well	88%
Fairly well	11%
Not so well	1%
How often do you and your adoptive child enjoy spending time together?	
Just about every day	97%
2-3 times a week	1%
Once a week	1%
Once a month	1%
How would you rate the communication between you and your child?	
Excellent	71%

Good	27%
Fair	2%
Poor	1%
Do you trust your child?	
Yes, very much	76%
Yes, for the most part	22%
Not Sure	1%
No	1%
Do you feel respected by your child?	
Yes, very much	78%
Yes, for the most part	18%
Not Sure	3%
No	1%
Do you feel close to your child?	
Yes, very much	92%
Yes, for the most part	7%
Not Sure	
No	1%

Overall, attachment relationships were very positive. The majority of parents reported getting along well with their children, spending time together they enjoy every day, good communications with their children, trusting their children, feeling respected by their children and feeling close to their children.

Behavior Concerns of the Children

Families were asked to report on a series of behaviors reported to be of concern to American families who adopted children with a history of institutionalization. The following table summarizes this information.

Behavior Concerns		
	Percent with behavior at placement	Percent with behavior at time of study
Hits self	2%	0
Rocks self	3%	4%
Always frightened or anxious	1%	1%
Inconsolable when upset	3%	4%

For the most part, there were no behavior concerns at placement or at the time of the study. For families that reported problems at placement, this changed over time.

The CBC subscales for children 4 to 18 years of age assessed withdrawal, anxiety/depression, somatic complaints, social problems, thought problems, attention problems, delinquency, and aggressiveness. Data were analyzed for the percent of children scoring in the clinical range of

each of these scales—the clinical range are those scores indicative of severe emotional and behavioral disorders. Some families left these questions blank or would answer a few and leave other items blank. Results were compiled for those cases that had complete data—only missing data results in the scales not being computed. As such, scales are reported for 53 of the 75 boys ages 4 to 18 (56%) and 66 of the 90 girls ages 4 to 18 (73%). The scales do not have norms for children under the age of 4 or over the age of 18, so these children are not considered in this analysis.

	Males 4-11	Males 12-18	Females 4-11	Females 12-18
Withdrawal Behavior	8%	8%	2%	0
Somatic Complaints	0	15%	0	13%
Anxiety/Depression	8%	0	0	0
Social Problems	8%	15%	11%	8%
Thought Problems	13%	17%	11%	0
Attention Problems	14%	8%	7%	14%
Delinquency	9%	0	5%	0
Aggressiveness	3%	0	4%	7%

For the anxiety/depression and aggressiveness scales, there was a significant difference for parents living in and outside of Pune. Families living outside Pune saw their children as being more anxious/depressed and aggressive than families living in Pune.

The results mean that most children do not have high enough scores that would be indicative of severe emotional and behavioral problems. For most of the scales, it was the same few children who had all the difficulties. Thus, the majority of children do not have behavior problems with the multiple measures used to assess behavior.

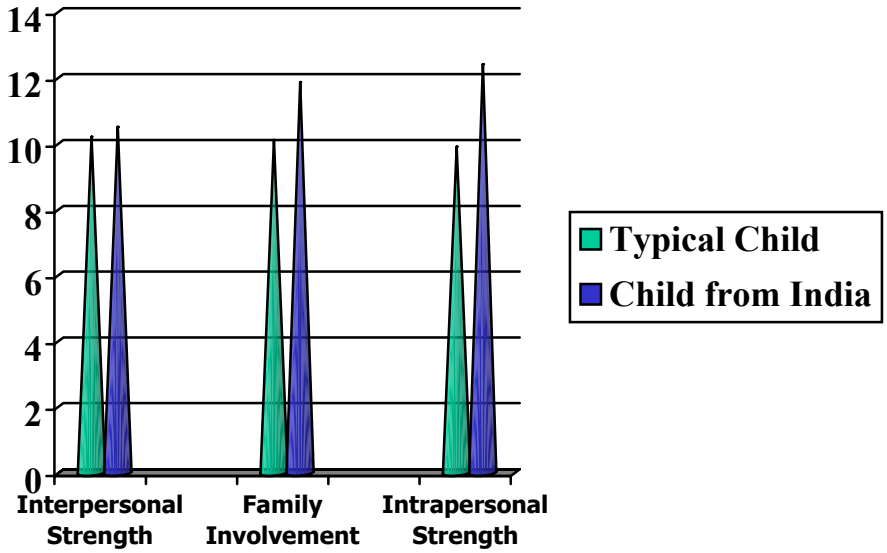
One parent in particular had an interesting perspective on their child's behavior. At the time of the study, the child was in late adolescence. The mother wrote:

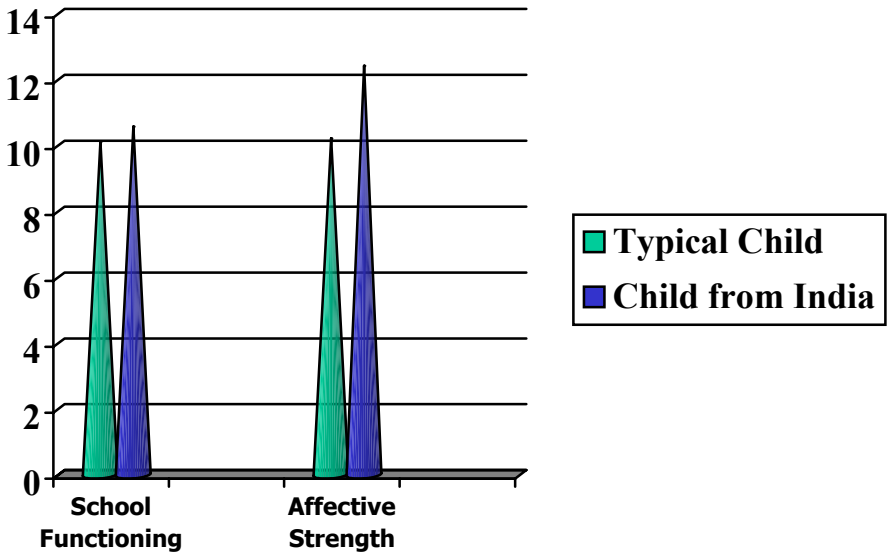
> Although the childhood of our daughter is precious to us, my spouse and I have forgotten the problems we faced, as it is our duty and pleasure to help her grow.

This comment helps parents who may be in the middle of difficulty understand that children will change and the issues that may cause them difficulty may dissipate over time.

Strengths of the Children

Drawing from a strength perspective and to give balance to the project, we asked families about the strengths of their adopted children. The research instrument we used measures 5 areas of strength. To compute standard scores for comparison, the scores for the typical child in the United States were used (i.e., children without emotional and behavior problems). All families easily identified strengths. The following figures provides the data on strengths.





There was a significant difference for parents living in and outside of Pune in the area of affective strength of their children. Affective strength refers to the ability to receive and give affection. Families living in Pune reported greater affective strength than families living outside Pune. Overall, the adopted children scored similar in each area of strength compared to children in the United States, with slightly higher scores on family involvement, intrapersonal strength and affective strength.

Family easily identified strengths and even when they didn't complete the scale, many would answer the open-ended questions at the back of the scale. The following is an example of what parents would write when asked about the best things about their child. The comment has been edited but other is verbatim from the adoptive mother.

> Our child doesn't speak wrong about others. He doesn't speak about the wrong qualities that a person has nor does he gossip about others and so there are no fights between people. Whatever the situation, he faces them as they come, without quarreling, and always keeps himself in a happy mood. Whenever he goes to some person's house he gets along so well as though he is a member of that particular family and he behaves well with them so that he is the favorite of all.

An adoptive father wrote:

> Our child is very creative. She loves to acquire knowledge.

Another wrote:

> *Our daughter* is a lovely kid and her arrival in our home was the single most important event in our lives. She is always cheerful and keeps smiling all the time. She is kind and exhibits warm feelings. She is quite a talkative kid and has got a terrific sense of humour. She has a sharp intellect and a good memory.

Parenting Scale

There was some confusion in completing the parenting scale. Some families left it blank, some families put check marks over items, and only a few circled responses. About 28% of families did not complete the items for the scale.

The authors of the parenting scale provide comparison data of Indian families to 2 groups of American families. One group is mothers attending a clinic because of extreme difficulties in handling their children (designated as "Clinic Mothers"). The nonclinic group were mothers whose children attended a university pre-school or volunteered to participate in the study (designated as "Nonclinic Mothers"). For comparison, only the scores from mother reports from India are used. The following table provides the mean, with standard deviations in parenthesis, for the three groups.

	Clinic Mothers	Nonclinic Mothers	Indian Mothers
Laxness	2.8 (1.0)	2.4 (.8)	3.5 (.88)
Over-reactivity	3.0 (1.0)	2.4 (.7)	2. 7 (.96)

Verbosity	3.1 (10.)	2.6 (.6)	4.2 (96)
Total	3.1 (.7)	2.6 (.6)	3.2 (.62)

Results suggest that India adoptive mothers are more lax and verbose than clinic and nonclinic American mothers, and score in the mid-range between clinic and nonclinic mothers on over-reactivity. Overall, they score more similar to clinic mothers than nonclinic mothers on parenting skills. Since the scale was normed with American mothers, the differences may be due to cultural differences between mothers from India compared to the United States rather than any difficulty in parenting skill. Further analysis will explore the relationship between parenting and child behavior and adoption stability.

The Adoption Process

Information about the adoption process comes from predominantly from family interviews, although some also came from written comments.

In making the decision to adopt, many families talked to other family members (29%) or friends (5%) or reported talking to both family and friends (24%). About 19% of the families reported that the process was not what they expected; most often they reported that they had no idea of what to expect (48%).

Most adoptive parents experienced support from their families about their decision to adopt (71%). Over time, adoptive parents experience more positive support from their families (91%). About 5% of families reported that relatives were negative about their adoption initially but the negativity had disappeared over time. Initially, families reported that about one-fourth of their relatives had mixed feelings about their adoption at placement; this had decreased over time to 10%. Upon adoption, about half reported that neighbors and/or their family had a party or special event to mark their adoption.

Many families felt that they were prepared for the adoption and the changes that adoption would incur. However, about 10% did not feel prepared and about 24% did not anticipate the changes in their lives once the child arrived. Even without the anticipation, most families were positive about changes and only 5% reported that the adoption caused disputes. As one adoptive mother commented about how preparation could be improved, she wrote:

> *Adoptive parents* need to know that the first month is a period of adjustment for the parents and the child. The child cries a lot because it is adjusting to a new environment. Parents need to bring their social life to a complete halt for the first few months in order to be less tired and enjoy their new baby.

An adoptive father suggested that parents who have adopted should meet with parents applying to adopt to get first hand knowledge from a parent perspective. This would enhance the serviced provided by the agency. Many families commented on the need for more visitation between parent and child before placement.

The majority of families were satisfied with the adoption process (53%) and reported it went as they expected (57%). About 14% were not satisfied and the same percent found the process more difficult than they expected. A significant percent (43%) reported that their child had some type of medical problem during the first 3 years of the adoption but a similar percent (38%) reported no problems. The vast majority of families (91%) reported that the child fits very well into the family.

In examining what single thing would have been most helpful if done differently, the following is an example of comments made by parents:

> The waiting period to completion of the adoptions should be less. If this period is less, children will not have to spend time in an institution and they will get the love at an earlier stage.

Adoption Stability

Several items were used to assess adoption stability. Families were asked to evaluate the impact of the adoption, the smoothness of the adoption over the last year, and how often they think of ending the adoptive placement. The following table summarizes the findings.

INDICATORS OF ADOPTON STABILITY

Overall, has the impact of this child's placement on your family been:

Very positive	84%
Mostly positive	13%
Mixed: positives and negatives about equal	1%
Mostly negative	1%
Very negative	

Overall, during the past year has the adoption been:

Smoother than expected	53%
About as you expected	38%
Had more "ups and downs" than you expected	9%

Have you ever thought of ending the adoptive placement

Yes	4%
No	96%

How often do you think of ending the adoptive placement?

Frequently	2%
Most of the time	1%
Not very often	4%
Never	93%

Approximately 97% of respondents rated their adoptions as having positive effects on their families. There were variances in the smoothness of the adoptions: about half reported their adoptions were smoother than expected; 38% reported the experience to be about what they had expected; and 9% reported more ups and downs than expected. While the majority of families have never thought of ending their adoptive placements, almost 7% have had some thoughts of ending their placements.

Following is typical of the comments parents wrote about their children. An adoptive father writes:

> We are satisfied about our decision and experiencing such joy that cannot be described in words.

Talking About Adoption and Birth Family Information and Issues

During interviews, families were probed about birth family information. When the child was abandoned (25% of cases), the families had no information. In about 10% of the families they refused to share birth family information. For those who had information about the birth mother, she ranged in age from 13 to 35 at the time of the child's birth; on average she was 20.9 years old (std. dev.=6.0). About 25% of birth mothers were under the age of 17 at the time the child was born and 50% were under the age of 20. About 20% of birth mothers were students at the time of birth, 37% were laborers, 20% were unemployed and 20% worked as domestics or were a housewife. Education ranged from illiterate to 15th grade; average grade was 7.6 (std. dev.=4.1). Most birth mothers (63%) were single and about 18% were married at the time of the child's birth.

Far less information was available on birth fathers. For those who had information about the birth father, she ranged in age from 21 to 50 at the time of the child's birth; on average he was 27.4 years old (std. dev.=8.1). About 25% of birth fathers were under the age of 22 at the time the child was born and 50% were under the age of 25. About 11% of birth fathers were students at the time of birth, 44% were laborers, 20% were professionals, 6% were unemployed and 6% were in the military. Education ranged from illiterate to 12th grade; average grade was 7.8 (std. dev.=5.3). Most of the birth fathers were single (54%) and about 18% were married to some one else other than the birth mother.

About 60% of the children were available for adoption because the parents were unmarried and the child was born out of wedlock. As mentioned above, 25% were abandoned. About 7% of the children were placed for adoption due to poverty, 1% due to incest or rape, and 7% due to personal or social problems in the birth family.

Families were asked how they discuss adoption with their child. In many cases (38%), the child had not been told that they were adopted. In about one-fourth of the families, the parents initiated discussion with the child. In about one-fifth of the families, the adoption was disclosed at the BSSK office or through BSSK. In only about 14% of the families did the child initiate

discussion and in 5% a relative initiated the discussion. However, 38% of the families reported that the child felt comfortable discussing their adoption, although only 10% of the children every initiated conversation about their adoption. Almost half of the children do not know what birthmother means (47%). The conversations about adoption was anxiety producing for many families and many of them discussed how they needed assistance in talking about adoption with their child. They also commented about needing help as the child gets older in dealing with adoption issues. They struggled with the nature of discussions when children were at various ages and wanted more preparation and assistance in dealing with adoption issues over time.

Families were also asked about issues related to search, both for the child and for the child's birth parents. Most families (57%) felt that birthparents should have no information about their biological child after placement. While most reported (52%) that they would help or be supportive if their child decided to search for his or her birth parent, almost half (48%) would discourage their child. For those who would discourage it, half would do so because their feelings would be hurt. If the agency contacted the family because the child's birthmother wished to share information or pictures, about half (54%) would oppose such contact. The other half gave varying responses, from letting the child decide (14%), the adoptive parents would decide at that time (14%), allowing the agency to share some type of information (5%), or allowing this after the child was older (10%).

Like the issue around discussion adoption, issues around search and the birth family were anxiety producing for parents. It seemed that the earlier a child is aware of adoption and made comfortable with the idea, the parents are comfortable with the idea of adoption and the child fares better. The older a child is when told, or worse of all discovers it from someone other than the parents, the more difficult the process of acceptance.

Service Importance, Use and Needs

Importance of Services to Adoptive Families

The questionnaire asked families to evaluate the importance of the following eight different types of services:

TYPE OF SERVICE	DESCRIPTION OF SERVICE
Financial Support	Adoption subsidy, insurance for health needs, financial help with needed services, etc.
Information About Child	Information about the child's placement experiences prior to adoption as well as current health, educational, and social needs.
Information About Services	Information about services and help in locating needed services such as subsidy, therapy, support groups, medical care, educational services, etc.

Medical and Health Services	Ongoing medical and dental care as well as specialized care to meet child's needs (medical care for disability, physical therapy, mental health services, etc.).
Educational Services for Child	Ongoing and specialized educational and academic services.
Parent Education and Counseling	Education or counseling about special-needs adoption including behavior management skills, helping the child adjust to a new family, dealing with a handicaps, stresses and rewards of adoption, planning for child's future, etc.
Respite Care and Other "Helping" Services	Planning some time away from the child as well as parenting tasks such as transportation, in-home nurse care, day care, etc.
Contacts with Other Adoptive Families	Adoptive parent support groups as well as informal contacts with families who have adopted

Families were asked to evaluate the importance of each of these services. Many families (27%) did not respond to these series of questions. The following table presents the results for respondents.

Parent Evaluation of the Importance of Various Services (percents)

	Essential	Very Important	Somewhat Important	Not Important
Information about child	59	23	5	3
Information about services	36	31	23	10
Medical and health services	45	36	8	11
Educational services for child	37	35	13	15
Parent education and counseling	49	28	19	4
Respite care and other services	14	20	35	31
Contacts with other adoptive families	23	18	39	20

The majority of families evaluated most services as essential or very important, except for respite care and contact with other adoptive families, which they evaluated as somewhat or not important. Thus, the majority of services were considered to be important to families.

As families commented:

> Parent education and counseling is of paramount importance in the adoption process and this should be made compulsory for adoptive parents. It is important because the process of adoption is complicated.

Post-Adoptive Services Used and Needed

Parents reported on the services they received after adoption, as well as services they needed but could not get. Even fewer families completed this information.

Parent Report of Services Used and Services Needed

<u>Services Used</u>	
Financial support	2%
Information about child	44%
Information about services	21%
Medical and health services	16%
Educational services for child	8%
Parent education and counseling	17%
Respite care and other services	3%
Contacts with other adoptive families	12%
<u>Services Needed</u>	
Financial support	2%
Information about child	2%
Information about services	1%
Medical and health services	<1%
Educational services for child	3%
Parent education and counseling	2%
Respite care and other services	2%
Contacts with other adoptive families	5%

Several points stand out. Many used information about the child. The question about social contact also asked families to evaluate how helpful these contacts were. Almost half (44%) said they were very helpful, 39% said they were somewhat helpful, and 16% said they were not really helpful. Thus, for families who had contacts with other adoptive families, this was a resource. Families also reported if they participated in an adoption support group. Only 30% did so. Over half (53%) said they were very helpful, 32% said they were somewhat helpful, and 15% said they were not really helpful. There was a significant difference between location of families and helpfulness of support groups, with 72% of families indicating they were very or somewhat helpful compared to 95% of families living outside Pune. The questionnaire probed whether

families had any contact with the agency since adoption. Eighty five percent of the families report contact. When asked to evaluate their contact, the majority (62%) said they were very helpful, 34% said they were somewhat helpful, and 4% said they were not really helpful. There was a significant difference between location of families and contact with the agency; only 43% of families from Pune had contact with the agency compared to 57% of families from outside of Pune. From these data, it seems that families living outside Pune relied more on the agency and evaluated the parent support group experience more postive than families living in Pune. This may be, in part, to the fact that families living in a large metropolitan area such as Pune have access to a wider array of services and opportunities for support and assistance than do families who do not live in a metropolitan area.

From the questionnaire, no service need was great. For the services needed most often, contact with other adoptive families was reported as an unmet need. As one adoptive mother commented:

> Adoptive parents need to be organized in many places so that thoughts and problems can be exchanged.

A few families who adopted older children commented that the social worker providing post-placement services was supportive to too young and without sufficient professional experience to assist them when issue arose. They recommended making sure that the social workers providing post-placement services have maturity of experience when working with families who adopt older children. Additional resources need to be developed for those who adopt older children. As one mother wrote who adopted a boy who was 5 years old at placement:

> It was quite a challenge to adopt a child with a traumatic past. I would have liked to read a few books to help the child. No book list was given or suggested.

The one area of concern to many parents was the court system. Many felt that it was unpredictable and some of the minority families (Christians, etc.) were concerned that would be be discriminated against in court. Many reacted negatively to the requirement imposed by the judge to put money in a trust for their adopted child. It seem to challenge family integrity and their motivation to adopt. One parent recommended that a representative of the agency, and particularly orphanage staff, should accompany the adoptive parent and that the court system needed to be more rational.

Summary

Excellent progress is being made with regard to domestic adoption in India. The BSSK adoption program responds to a need in the community. Families evaluate the agency practices positively and adoptions are quite positive. Most of the children are developmentally appropriate and have no health problems, sensory difficulties or behavior problems. Parents report good parent-child relations and the adoptions are very stable.

This section will summarize the answers to the questions posed initially in this report that guided the evaluation of the program.

What problems/issues are families facing related to the adoption/child?

The biggest issue for families was related to how to discuss adoption with their child. There are three ways that families can deal with adoption. First, there are families that reject/deny the differences between a family and birth and a family created through adoption. These families create a less open and less reality based home environment. Second, there are families that insist on differences and ascribe blame for difficulties to genetics or pre-adoptive history (i.e., everything bad is due to the child's "bad blood"). Third, there are families that acknowledge the differences openly, sharing concerns and feelings about their adoptive status. Depending on the family style of dealing with differences, families who deny or insist on differences are most at-risk for difficulties over time. Thus, families need assistance in dealing with adoption disclosure in order to reduce the risk for later difficulties.

Many families openly talked about their struggles with how and when to tell. Some wanted to use the interview as the opportunity to disclose the adoption to their child. Some refused to discuss adoption and had no plans to disclose the adoption to their children. The vast majority, however, struggle with how to discuss the issue, when to discuss it, what to do if a child didn't want to talk about it, what to do if the child wanted to talk about it all the time, and the issue of talking about adoption appropriate to the child's level of development. Some believed if it was mentioned when the child was young, there was no need to talk about it again. What emerged from the interview was clear indication that dealing with adoption issues, including the birth family, were ongoing struggles for many families.

In addition to this issue, families identified the court as a barrier to their satisfaction with the adoption. With minority families (i.e., Christians, Parsi), they were apprehensive about how the court would treat them. While their apprehension was not confirmed, it was still stressful for them.

A number of families commented on the court requirements to put money in trust for the child. For some families, the insistence on a trust made families feel that their integrity and motivation to adopt were undermined. For some, the amount of money requested was a burden, particularly if it was required all at one time. Families may benefit from having a social worker accompany them to court and for the agency building stronger relations with the court system. Pre-adoptive support and training may also help reduce family apprehension.

What post adoption resources they have found/would like to find?

There are no formal supports for the adoption and often families are very alone in their unique situations. Most of the families received informal support from their extended family and friends. For services needed most often, families suggested that they needed informal, social

contacts with other adoptive families. For families who received the newsletter, many commented on its usefulness.

What are the indicators of success in adoptive placements?

There are several indicators of success. Parent-child relations were extremely positive. Families evaluated the impact of the adoption on the family in very positive terms. However, some post-placement issues were identified. Some families may not have been well prepared for parenting or the adoptive experience, or did not have the support they needed. As such, at least some families had entertained thoughts of ending their adoptive placements. Fortunately, only a few families explicitly expressed this thought. Overall, adoptions are quite successful by any of the measures used in the study.

How could BSSK's adoption program be improved?

Recruitment/Marketing. Recruiting families is an ongoing process. Many families talked about thinking of adoption for 2 years before they made any concrete steps to pursue adoption. They would see items in the newspaper and cut the article out for future reference. Their comments suggest that child adoption and BSSK need to have an ongoing presence in the media because of the time from awareness of the issue to action. In essence, the media coverage in 2001 may not result in more families until 2003. This recommendation is similar to one made by Raju (1999) of the need for ongoing promotion of adoption.

Families often try fertility treatments for many years. Some reported trying treatments for 17 years. Families need better information about fertility treatment (i.e., after 5 years most families do not conceive and age of the mother affects success rates). Along with better information, they need to learn about the adoption option much earlier in the process. In fact, many families wished they had adopted earlier than they did. It is important to get adoption information sooner rather than later, indicating the need for more public awareness campaigns.

More families need to be recruited to meet the demands for placement of children who cannot reside with their birth families. In addition, recruitment and family preparation activities need to be oriented towards assisting families in making social connections with each other and building networks of informal social support. While not all families want social contact with other adoptive families, a substantial percent of families either had social contact—which they evaluated as helpful—or wanted social contact with other adoptive families.

A parent advisory board may be helpful for several reasons. Parents can assist in recruiting and marketing of domestic adoption to other families. Adoptive parents have a different type of credibility in the community than do social workers and adoption professionals—they can be a great asset in locating other families for adopting abandoned children. In addition, families know their own service needs as well as the service needs of other families in their communities—they can advise the agency on programs to be developed that will strengthen and support families.

Community marketing and public relations would strengthened the domestic adoption program. There is a critical need for public education campaigns that present accurate information about adoption, adoptive parents, and adoptees. This must include working with the media to provide this information.

Child Preparation for Adoption. Children, even though they are infants and toddlers, need to have pre-adoptive preparation activities prepared for them by adoption workers. In particular, life books should be continued as standard practice. The life book is a scrapbook that contains photos as well as other mementoes, drawings, and memories that form the child's life experiences before adoption (Wheeler, 1978; Aust, 1981). Included in the life book should be a placement genogram (McMillen & Groze, 1994). The placement genogram is a diagramming technique that traces the child's placement history starting from birth and records pertinent information about each placement. For instance, the date of abandonment, the dates the child was moved to various placements, and relationships with significant caretakers might be documented on the placement genogram. Whenever possible, this should include photos of the caregivers. This information can help provide insight into the issues raised by adoptive families as they try to understand the child's behavior and its impact on their family (Hartman & Laird, 1983). When children are older, it can be used to help children connect and integrate their past to the present.

More resources for children, such as story books and stories, that have adoption themes as a metaphor need to be developed. One family shared the book that they had created in Marathi. Other parents, adoptees and artists/book writers should be encouraged to develop additional resources for different ages of childrren that can be read to and shared with adopted children.

Parent Preparation and Support. Many of the current activities should be continued. Almost all the families commented that in retrospect, while they were frustrated by the wait and process at the time of application, it was helpful. If families who had adopted could be matched with applicants early in the process, some of the frustration could be lessened as families meet and get support from other families who have been through the process. In addition, this helps begin informal support systems as other questions arise, both throughout the adoption process and after placement.

Better post adoption support is needed for families. One support that many families commented on was the need for parent seminars and education groups. They would like to attend groups about general parenting issues, child development, telling your child about adoption, and telling your family and friends about adoption.

In addition to ongoing training and parent groups, another way to develop post adoption support is through the use of newsletters, where families can read about issues, parenting tips, and events. The current newsletter should be continued and perhaps expanded. A newsletter can also serve as a marketing tool to recruit other families. In addition, a lending library that includes books on adoption, child development, and parenting would give families easy access to resources that some feel might be helpful.

Formal services need to be developed to strengthen and support families, particularly as the child gets older and different issues arise. About 10% of families are dealing with children with significant emotional and behavioral problems. It is important for families to have easy and early access to mental health and counseling professionals who are sensitive to the unique issues in adoption. For the majority of families, access to social workers and adoption specialist who are knowledgeable and skilled for the different issues that emerge as children age is essential. Having the ability to easily make contact with professionals can reduce family stress.

Management Information System. On an administrative level, there is need for improvement in the Management Information System (MIS). In order to conduct a stronger program evaluation and to understand better the issues faced by families post adoption, there is a need for better monitoring of families after the adoption is finalized. Families cannot be monitored if they cannot be located. Since this is the first systematic program evaluation, the agency learned about gaps in their records. They also began to think about how to use other information that they collect. The agency should continue to invest in the MIS system, learn ways to use the data they currently collect for planning and evaluation, and expand other data collection and evaluation strategies that could inform policy and practice. The agency staff and activities are a rich resource from which more can be learned. The collection and use of information should be a priority for agency management and planning. Such a priority will strengthen an already strong agency.

Family-based care before adoption. While the residential facility for care of children waiting adoptive placement is excellent and could serve as a model residence for other countries, the heavy reliance on institutional-based care compared to family-based care is problematic. Even in the excellent facility of BSSK with good programming, services, staff and nutrition, children were observed engaging in self-stimulating behaviors such as rocking. A good institution is not a substitute for a family. BSSK must examine its values and planning around the expansion of foster care and the reduction or elimination of resident/institutional care. Children will benefit more greatly from family-based care, both in the short term and the long term. Other countries in the region such as Thailand has moved to such a model of service delivery. They may be helpful as BSSK considers their options.

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